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SCOTTISH HEALTH SERVICES COUNCIL

HOSPITAL MEDICAL RECORDS IN SCOTLAND

Development and Standardisation

REPORT OF A SUB-COMMITTEE OF
THE STANDING MEDICAL
ADVISORY COMMITTEE

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HOSPITAL MEDICAL RECORDS IN SCOTLAND

Report on Development and Standardisation

PART A — GENERAL

I. Introduction

1. At their meeting on 27th February, 1964, the Standing Medical Advisory Committee agreed to set up a sub-committee with the following terms of reference:

> "To consider medical records systems in Scottish hospitals, their present and potential functions and the possibility of standardisation in the light of the forthcoming report of the Standing Medical Advisory Committee (England and Wales)."

2. That report was published in September, 1965. It was drawn up by a Sub-Committee of the Standing Medical Advisory Committee (England and Wales) under the chairmanship of Professor R. E. Tunbridge. We shall refer to it in our report as the Tunbridge Committee's Report.

3. The first meeting of the Scottish committee was held on 15th June, 1964 and subsequently sixteen meetings were held.

4. We were aware that throughout the hospital service in Scotland there were already many groups and individuals acutely interested in improvement of the medical record itself and of its processing. Because of the size of the country, and the range of interests represented by the members of the Committee, we have obtained directly or indirectly information on current development and the current thought of most interested parties.

5. We began our study by sending a questionnaire to nine selected hospitals throughout Scotland. From the completed questionnaires and the sets of medical records submitted, it was clear that there was much interest in creating "order in the medical record" although individual records varied widely in layout, methods of filing and size.

6. We therefore divided into small working groups, each considering and reporting on some aspect of the record or of the system. These groups considered the recommendations, where relevant, of the Tunbridge Committee.

7. We are in sympathy with the broad principles of the Tunbridge Committee's Report. Since our remit, however, was more comprehensive we have prepared our report in a different order. Cross reference to the Tunbridge Committee's Report is made where relevant.

8. It must be made clear that we were not asked to confine ourselves to 'standardisation' but to look at and make observations on 'systems'.

9. In this time of technical advance, mechanical means of preparing, processing and storing medical information are well developed. We are, however, nowhere ready to accept the need for mechanical processing nor are the records themselves suitable to be so processed. Indeed the perfection of the mechanical

systems may far exceed the accuracy or value of the information stored. Since data required for management is easily extracted, it seems likely that developments to handle such data will proceed more rapidly than the development of techniques to handle clinical information, whether needed for the immediate care of the patient or for statistical or research purposes.

10. Despite this practical aspect, it must not be forgotten that the most important aspect of the medical record is the clinical information which it contains. The primary purpose of the hospital service is the care of the patient and whatever degree of standardisation of medical records is accepted, or whatever mechanical devices are used, the medical record systems must, in addition to any other purpose which they serve, be clearly shown to be of immediate advantage to the care of the individual patient or to be directly of help in the future in improving the techniques and standards of care, and to be of value to research in all its forms.

II. The Present Problem

11. Medical records can and should be used for a variety of purposes. We found in the course of our deliberations, that opinions differed widely on which was the most important use of these records, and that the degree of importance accorded to each use depended on the interests of the individual. It is, however, seldom appreciated that each record has to be expressly designed for the purposes for which it has to be used. In view of the many uses to which an individual record may require to be put, great care is necessary in designing the record to meet the needs of both the clinicians and the recording techniques.

12. The requirements of, (a) immediate clinical care of the individual patient, (b) future care of the same patient, (c) utilisation for clinical or epidemiological research, (d) obligations for legal purposes, and (e) provision of information for management (now and in the future), all make different demands. In our view some or other of these requirements are not met under the present systems and cannot be met by the present methods of handling data.

13. The form of the medical record indeed owes much more to past custom than to present needs and it is certainly not designed to serve the needs of the future.

14. The common link between the various uses is, of course, the information contained within the record. There is a risk, however, that undue emphasis may now be placed on the vehicle, i.e. the physical form of the record rather than on the information contained therein, its accuracy, its detail and its usefulness; and also on the ultimate methods of storage and retrieval of the information.

15. At the moment there is a huge accumulation of information in medical records, stored in narrative, tabular and graphic form often without any link between various items of information and without attempt to correlate information either between specialties or often within the same specialty at the same or different times. The usefulness even for clinical use is now questionable,. since in many hospitals insufficient time and care is spent arranging the contents within the case folder and in preparing an accurate summary after completion of the individual admission. The remarkable growth of recorded information associated with the increasing intensity of medical investigation and

therapy is such that the very volume may limit the usefulness of the record even in the immediate care of the patient. Certainly much information is being recorded which is not fully used. Methods must be devised whereby this valuable information can be fully utilised.

16. The present methods of compiling case notes and processing the information therein cannot possibly meet the future demands for information. Automated systems capable of meeting such demands cannot handle the case record in its present form.

17. To ensure effective use of information in future records full consideration should be given now to the preparation of the record in such a way that automatic data processing equipment can handle a large proportion of the information.

18. Any changes proposed should satisfy a number of conflicting requirements. Information concerning an individual patient must be (a) readily available to the clinician in a form which he can understand and evaluate, (b) in a form capable of classification and coding by suitably trained clerical staff, and (c) capable of interpretation for the purpose of clinical research and for investigation into the epidemiology, and progress of disease processes.

19. At all stages the information should be checked for factual accuracy in so far as this is possible.

20. Under the present system few, if any, of these requirements are completely met, and we must consider why this is so:

Recording

The problems associated with the actual recording in the ward, clinic or laboratory raise the following questions:

(a) What information should be recorded, how extensively, in what form and how much should be retained?

(b) Can clinical judgement and observations be quantified, or is this a research study in itself? Can the notes of one doctor be made acceptable and fully meaningful to another at some later date?

Processing

(a) How can records best be summarised, indexed, stored, and retrieved?

(b) How are mechanical methods of data storage and processing to be introduced?

(c) For which purposes are computers essential and for which purposes are other systems better suited?

Linkage

How can all the medical records of an individual held by all the agencies of the community health services be linked so that, for example, the progress of the patient after discharge from hospital may be readily assessed?

Research

Is it possible to design records and records systems so as to make the information more readily available and suitable for research purposes?

21. The problem of communication between all those engaged in different

fields of health care poses special difficulties. Changes are often introduced in isolation without consideration or awareness of the legitimate requirements and desires of others.

III. Future Development

22. When changes are made with the intention of improving existing records the ultimate transfer of the information to some form of computer storage should always be kept in mind. Conversely innovations which facilitate computer storage should be so designed so as to be understaudable to the clinician.

23. In many fields it is not appreciated that the future techniques of processing records will be developed only with effort and experience. At the moment it would be relatively easy to process good summaries and this should be initiated. The case record of each admission should be summarised to provide (a) such information as is required for national statistics and (b) a full clinical summary of the case. Clinical summaries could in the first instance be narrative in form but specialties within hospital groups should be encouraged to experiment with the development of specially designed summaries which could be coded for automatic data processing.

24. A properly designed medical information system extends far beyond the confines of the hospital. Technically such a system is possible now but it can only become a practical reality if the organisation and planning is begun in the near future. The biggest single problem to be overcome is the absence of machinery for co-ordination of the views of those interested. It might be possible to develop such an interest by co-operation between various bodies concerned such as the Association of Medical Records Officers, the Registrar General of Births, Deaths and Marriages (Scotland), National Health Service Executive Councils, Medical Officers of Health, Universities and Hospital Boards.

25. Since, however, no real advance is ever made on the broad front, individuals or groups who are actively interested in such development should be encouraged to undertake pilot studies which would provide not only a stimulus to others but positive information on which later and more general advances can be made. Such experiments in development and co-ordination should begin now and active support given to the participants in the form of research grants etc.

26. Regional Hospital Boards should set up a medical record and data processing section to develop medical record systems and encourage research activity within their own region. It is suggested that this section might be responsible for developing co-operation between the various interested bodies such as those referred to in paragraph 24.

27. In addition we recommend that hospital groups should establish group medical record committees, if not already in existence, to consider and decide on the form and content of hospital medical records to be used in their own group.

IV. Medical Record Terms

28. We have accepted in general the definitions given in the Tunbridge Committee's Report and those relative to our Report are reproduced in Appendix A.

PART B — GENERAL PRINCIPLES AND RECOMMENDATIONS

V. Confidential Nature of Hospital Medical Records

29. Every effort should be made to preserve the confidential nature of medical records. This cannot be overstressed and must always be borne in mind by those who have to handle such records. Bodies who have administrative control of medical records should take steps to instruct all staff having access to such records of their highly confidential character. The records should never be left in a position where the patient, the patient's relatives or unauthorised persons can obtain access to them. Certain records, such as those relating to temperature, pulse and respiration rate, to treatment and to other matters of communication, may, for convenience, be placed in the proximity of the bed but the main body of information which is contained within the case folder, must always be kept in a suitable container or trolley in the ward office or similar accommodation. Patients should never be asked to take their own records to another department unless they have first been placed in a sealed container.

30. Personal medical information submitted to the Scottish Home and Health Department is always treated as highly confidential and access to such information is never given to an unauthorised person. Access to the hospital record of the individual can be obtained only with the consent of the consultant concerned. Personal access to an individual patient should be made through the family doctor.

VI. Preservation of Hospital Medical Records

Medical Records Proper

31. Current guidance on the preservation and destruction of hospital records is given in S.H.M. 58/60. This draws attention to the Eighth Schedule prepared in terms of Regulations dated 10th December, 1940 (SI 1940/2107) which is the current statutory authority governing the destruction of certain classes of hospital records, including medical records. Any document which is intended for permanent preservation because it contains matter of historical interest cannot be destroyed. According to these regulations therefore the majority of the records with which we are concerned in this report must be retained for *at least* six years following the discharge of the patient or three years after the patient's death if he dies in hospital.

32. We consider that medical records, other than those of a transitory nature, should be retained for at least 25 years after a patient's last visit. Retention of individual records or of groups or classes of records, in whole or in part, after that period of time should be permitted when a request is made by interested clinicians or research workers in any field. It may be argued that this recommendation could produce a storage problem but we believe that this problem will be overcome in the near future by the application of computer and other techniques resulting in less bulky storage of such records.

33. Although we recognise that storage of summarised records would be easier we are not entirely convinced that such storage can replace some of the excellent detailed records now being compiled in some areas.

34. However, we believe that the retention of case records permanently in the hospital is unrealistic. It should be possible to contemplate some form of cheap

storage, perhaps on a regional basis. This would imply two levels of storage — (i) in the hospital for six years after last use of record and capable of instant recall and (ii) less effective storage thereafter on 24/48 hour recall.

35. Micro-film can of course be considered as a means of reducing storage bulk. In general, the position as indicated in the Notes to Eighth Schedule, is that any document of which the Schedule authorises the eventual destruction may be micro-filmed after three years, the original then being destroyed and the micro-film retained for at least the remainder of the statutory period. (See paragraph 31.)

The preservation of histological material

36. The diagnosis and subsequent treatment of a patient is frequently dependent on the histological examination and interpretation of biopsy material. The histological material may therefore be deemed to be part of the recorded evidence relating to a patient's case, and it may be held that by current law there is a legal obligation to retain such material, properly filed, in the pathological department for the minimum period of six years applicable to medical records themselves. It is recommended that where paraffin processing has been used, blocks containing tissue relevant to diagnosis should be preserved. We understand that it is the practice in most Scottish laboratories to file one or more, stained or unstained, sections on slides; this is convenient for review of the material. We recommend, however, that as in the case of the main medical records (paragraph 32) all paraffin blocks embodying tissue which reveals pathological process should be preserved for at least 25 years. Where only frozen tissue has been sectioned, without subsequent paraffin embedding, every endeavour should be made to retain one or more permanently stained and mounted sections.

The preservation of X-ray films

37. We consider that X-ray films are part of the case record and should be subject to the same period of retention i.e. a minimum of six years by current law. We further recommend that as in the case of histological material all X-ray films demonstrating abnormal conditions should be retained for a period of at least 25 years. As methods of copying or tracing become available it should be possible to insert in the case record a reduced negative or positive which will reduce the need for extensive storage.

VII. Unit System and Identification

38. The unit system is a generally accepted method of hospital record keeping whereby all the admissions to and contacts with a single hospital, or a group of hospitals, concerning the same patient are brought together in one folder. This method provides a unique identification system for the organisation of centralised records departments but the scope and operation of the system may have to be varied from one area to another. Clear distinctions must be made between unit systems for individual hospitals, for hospital groups and for regional hospital board areas.

39. A standard unit system throughout the hospital service does not completely meet this point. At present a patient could have similar clinical records

in more than one unit system and without considerable reorganisation these could not be brought together. If on the other hand, *all* relevant clinical papers were brought together then the sheer size of the records folder would in some patients' cases hamper the individual clinician in the use of his own notes.

40. The introduction of unit systems (which it is agreed are basic to the efficiency of any scheme) must therefore be organised within a regional plan. One practical solution to this difficulty would be the establishment of a master index for each regional hospital board area for the identification of patients. This would provide a register of patients treated within that region to which all hospitals and other interested bodies could contribute and have access. Techniques of preparation and maintenance of this index should be left to the regional hospital board medical records and data processing section whose establishment we have recommended in paragraph 26.

VIII. Standardisation of Documents

41. In our view at the present stage of development rigid standardisation of every document within the case folder (except within groups or hospitals) would be detrimental to patient care, to experiment and to future advance within the Service. It would result inevitably in compromise case sheets at the lowest common level. *We therefore recommend that standardisation should be confined to the following:* The case folder, paper sizes, the general heading of case notes (to allow easy recognition of given documents and recording of identification data), and certain documents which are referred to in a later part of this Report.

We think that it is undesirable to standardise the detail and the design of the record in the body of the notes. We see no reason why a specialist or special unit should not develop a form of case notes designed to suit best the situations in which they will be used. We recommend, however, that such specially designed records must meet the general rules of paper size, standard headings, etc. and that they should be approved by a group medical records committee.

IX. Filing of Documents

42. A patient's case record is compiled from a number of different sources so that the doctor in charge of the case has the information available at any time while the patient is in his care. We accept that the relative value of particular records changes with time and that some records will remain of the greatest relevance throughout the patient's treatment, while others, of the greatest consequence at a particular time, will be of much less relevance when superseded by later notes. We do not accept the principle that records can be divided into three classes viz. Primary, Secondary and Transitory according to the likely period of relevance. We consider that there are many documents (such as intake and output charts and other aides-memoires) which in the majority of units can be regarded as *transitory* and destroyed on discharge at the discretion of the consultant in charge of the patient. All other documents should be regarded as of permanent importance. Although in some instances it may lead to rather bulky case folders, all these records should be retained in the case folder on the patient's discharge.

43. It is difficult to suggest a filing sequence that will satisfy everyone. A

number of conflicting considerations have to be taken into account since what is best for one specialty may not suit another and what is most convenient for clinicians may be a burden for records staff. Inevitably some measure of compromise is necessary and whatever system is chosen the following criteria should be met:

(a) the views of the majority of requests made by various clinicians within a region or hospital group
(b) the provision of a logical sequence of papers
(c) an efficient handling system by the records staff
(d) reasonable economy in terms of bulk

44. There are two major but, unfortunately, conflicting systems favoured by clinicians.

These are:—

(a) filing according to specialty, so that each specialty maintains its own continuing record dealing with the patients' attendances and admissions to a particular firm or clinic.
(b) filing in strict chronological order within episodes of illness so that the entire sequence of events affecting an individual patient would be arranged in the order of their occurrence.

Because of this major conflict we prefer not to dictate to hospitals which system should be adopted. There are advantages in both systems and we consider that regions and hospital groups should be allowed to develop a method compatible with their existing systems and favoured by the majority of their medical staff.

45. Details of the advantages and disadvantages associated with the two filing systems are given in Appendix B. The sequence of documents and the method of fastening within the folder depends on the filing system to be adopted. These are also described in Appendix B.

Numbering of Documents

46. As and when standard documents are provided for use throughout the country, there would be advantage in numbering the documents for ease of identification. The nomenclature shown in the model documents in Appendix E could be used nationally.

X. Mechanical Processing

Present Methods

47. It is essential that encouragement be given to the introduction of mechanical means of initiating the documentation of patients being admitted to or attending hospital. Basically this involves the use of mechanical devices which reduce the repetitive writing of information on to clinic sheets, laboratory request and report forms and other documents.

48. Although it is not the purpose of this report to discuss the merits of particular types of equipment, it is suggested that thought be given to a recently introduced method of documenting patients. This involves punched tape or cards from which labels, bearing registration details of the patient, can be printed.

49. Essential identification data of each patient must be recorded on the inside frontpiece of the folder (see paragraph 66 on design of the folder). In

this respect the minimum to be provided for should be full name, address, identification number, date of birth, marital state, sex and religion. This information can be contained within a space measuring 4″ x 1″, which is the recommended size of label and can be subsequently printed out on all documents contained within the folder. Additional details e.g. nearest relative, required for administrative purposes need only be shown on the folder and it is suggested that this can be handwritten as they are not required elsewhere and would increase the size of the space given above out of practical proportions. Ultimately for the purpose of data linkage, thought should be given to making provision for the maiden name of the mother or the patient's maiden name (in the case of married women).

Future Methods

50. The handling of information by mechanical and electronic means is limited less by a shortage of suitable equipment than by the absence of people experienced in the application and development of techniques appropriate to their field. This is particularly true in Medicine.

51. Advances in data processing techniques are so rapid that it is unwise to suggest the type of equipment most suited to the handling of medical information. Some of the newer techniques could with advantage be adopted in the National Health Service and we feel that the hospital service provides a suitable medium for investigation and elaboration of new methods. Much organisation and planning will be required before such systems can be efficiently introduced.

52. The advantages of electronic mechanisation (infinite capacity, phenomenal speed and complete accuracy in repetitive procedures) should overcome the difficulties currently restricting the effective utilisation of the rapidly accumulating mass of medical information. Before these advantages can be exploited a number of problems must be overcome. First, a sufficient number of people within the Health Service must understand the application of computer techniques to their disciplines or departments; secondly, the form of standardisation of medical records suitable both to computer requirements and clinicians' needs must be determined; and thirdly, the regional organisation necessary for the complete utilisation of a computer's facilities must be developed. The longer this is delayed the greater will be the difficulty in finally introducing electronic systems. Many experiments are taking place in the use of computers for the storage of medical records, but the absence of a co-ordinated and continuing plan of study will mean that advances in equipment and facilities will continue to outstrip application. More versatile and cheaper equipment will inevitably become available in the next few years but the primary organisation of data is basic to all systems and if initiated now would allow the adoption of the most suitable equipment at an appropriate point in the future.

53. A Health Services Research and Intelligence Unit has now been established by the Scottish Home and Health Department. The object of setting up this Unit is to have available a group of officers relieved from day-to-day administrative responsibilities who will be able to collect and analyse information about all aspects of the health services, study long term trends and thus provide those responsible for making decisions about future policy with a sound, factual basis for these decisions. As this Unit is already engaged in activities closely allied to the development of medical record systems, we recommend that one of its

functions should be the promotion of studies and research particularly into data processing and methods of medical record keeping.

XI. Centralisation

54. The principal document in relation to medical records which is used for central administrative purposes will be the Hospital In-Patient Records Summary Sheet which in its various forms — general, maternity, etc., forms the basis for the Scottish Hospital In-Patient Morbidity Statistics. This document must be standardised.

55. A similar document forwarded centrally is the "Cancer Registration Card" compiled from the medical records of patients in whom malignant disease has been diagnosed. We have referred the question of "Cancer Registration" to the Standing Cancer Committee of the Scottish Health Services Council.

56. It is appreciated that the information which is at present forwarded to the central department (paragraphs 54 and 55) from hospitals is of great value for defined central purposes. However we consider that adequate development of data processing of clinical records should become a serious concern at regional and group level.

XII. The Record Itself

Sizes of Hospital Medical Records

57. We recommend the following range of sizes approved by the British Standards Institution and commonly known as the International Paper Sizes, despite the difficulties that their introduction might create initially.

58. The Scottish general practitioner's envelope is larger (5" x 8") than the English envelope but size A5 does not fit. Accordingly we recommend that for most reports to general practitioners a special size should be cut, namely 4⅓" x 7". The carbon copy to be inserted in the case record will be size A5 which would leave a suitable margin for filing. When longer reports are necessary, we recommend the use of size A4. If in due course the size of Scottish envelope is altered, the paper size for the shorter reports to general practitioners should be revised to conform to an international paper size.

59. We therefore recommend the following sizes:

(a) The size A4 of the range (8¼" x 11¾"/210 mm. x 297 mm.) is a suitable size for most case papers.

(b) The size A5 (5⅞" x 8¼"/148 mm. x 210 mm.) is convenient for correspondence and certain reports.

(c) A new size 4⅓" x 7" is more advantageous for reports and letters to general practitioners and for most other reports.

We see no use for the size A6 (4⅛" x 5⅞"/105 mm. x 148 mm.).

Use of Colour and other Identification Symbols

60. We believe that there is great advantage in having a special colour for the Hospital In-Patient Records Summary Sheet. Not only does it draw attention to this sheet but it makes an easily identified division of each admission of the patient. We recommend that it should be printed on yellow paper. All other

documents for inclusion in the case folder should be of white paper. The use of colour flashes to denote a particular specialty is not a matter on which we wish to be dogmatic. Nevertheless we have evidence that this can reach a ridiculous situation where there are so many colours that their interpretation becomes impossible.

61. There is some value in a few colour flash systems to distinguish broad groups of laboratory reports. This number should be limited. It is recommended that colour flashes or a colour print system on a white background should be used and the following colours are recommended:

Bacteriology (including Virology etc.)	Blue
Biochemistry (including Endocrinology etc.)	Green
Haematology (including Blood Grouping)	Red
Pathology (including Histology, Cytology, Post-Mortem Reports)	Violet

62. All reports from other departments such as E.C.G., X-ray, etc. should be on white paper with black printing. The name of the issuing department should be printed on the bottom left-hand corner of all forms.

63. Unfortunately there is no suitable international paper size — adequate for reporting purposes — which can be mounted properly on a size A4 mount sheet and leave room for filing clips etc. We recommend that all report forms should be of a special size 4½" x 7".

Paper Quality

64. We accept in general the recommendations on paper quality made by the Tunbridge Committee and these are given in Appendix C. We believe that the permanence of the paper is important however and in view of our recommendation on the period of retention of main medical records, the quality of permanence of paper should be suitable for retention up to 50 years.

XIII. Format of Individual Documents

STANDARDISATION NATIONALLY

65. The documents detailed below could with great advantage be standardised within Scotland:

Case Folder
Hospital In-Patient Records Summary Sheet
General Practitioner's Letter of Referral
Prescription Sheet
Mount Sheet

Case Folder

66. We recommend that there should be printed on the outside of the case folder the name of the hospital, the patient's name and the identification number. In addition the words "The information enclosed in this record is highly confidential" (or some phrase to that effect) should be printed in bold type. The words "Not to be handled by the patient" could be added where considered advisable by the Group Medical Records Committee responsible for detailed design of notes. On the inside of the folder there should be (a) identification

data (see paragraph 49), (b) a chronological list of all new out-patient attendances and in-patient admissions to serve as an indication of the contents of the folder, and (c) a box headed "Warnings" and this should be sub-divided into Blood Group, Special Sensitivities and obligatory drugs e.g. steroids etc. The back cover should contain a "pocket" on its inner side. The case folder should be designed and produced centrally.

Hospital In-Patient Records Summary Sheet

67. We consider that the new Hospital In-Patient Records Summary Sheet, which we understand the Scottish Home and Health Department propose to bring into use in 1967 in place of the existing Hospital In-Patient Records Discharge Sheet, should serve as the in-patient identification sheet and be the first document of each admission. It provides information on the front of the sheet for central use under the Hospital Morbidity Statistics Scheme; the copy repeats this information for patient identification purposes with, in addition, space for a complete clinical summary of the individual admission. This summary should be developed at local level in such a way that the information may be used eventually for computer input. (See Figure 1).

General Practitioner's Letter of Referral

68. We observe from the material submitted to us that every hospital but one had a letter form for use by general practitioners for making out-patient appointments although these varied in style and size. It was represented to us that general practitioners who might use any one of several hospitals under different hospital authorities had to carry a stock of many different forms. This problem was more acute in the city areas.

69. A sample form was prepared which contained a section for the general practitioner's clinical notes which could be sealed off from the rest of the form thereby preserving confidentiality and leaving the remaining portion of the form for completion by the patient with the other necessary information to enable an appointment to be made. This sample form was submitted to the Association of Medical Records Officers and to four Local Medical Committees representative of the industrial and rural areas. The form was on the whole favourably received but certain revisions were made as a result of the helpful comments made by these bodies. The layout and content of the form is as shown in Figure 2 and the size of this communication less the gummed edges should not be smaller than A5.

70. We discussed the question of pre-payment of this letter form and agreed to accept the solution suggested in the Tunbridge Committee's Report, namely that standard pre-stamped forms should be issued by regional boards through executive councils to general practitioners.

Prescription Sheet

71. It is considered that a visible edge card system should be used for recording the treatment and drugs ordered by medical staff. This allows the prescription sheet to be taken round the ward (a) at times of medical visits and (b) subsequently on treatment rounds by nursing staff. In this connection our attention was drawn to the system (1) developed and now adopted after an

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(1) Crooks, J. Lancet, Feb. 13, 1965, pp. 373–378

experimental period by the Aberdeen General Hospitals in all wards and units in which a composite document is used to record drug prescription and administration. We feel that this system has much to commend it and suggest that such a sheet should be standardised for use in Scottish hospitals, including a record of drugs given (see Figure 3).

Standard Mount Sheet

72. The purpose of the sheet is for mounting X-ray, laboratory and other reports. It should be of heavy and good quality paper. The size we recommend is A4 and sufficient space should be left at the top for a stick-on mechanically printed label. It is important that the reports be mounted on it in such a way that at least half an inch of the bottom edge of each report remains visible so that the source of different reports is easily ascertained once they are mounted (see paragraph 93(b)). We see no reason why units should not decide to use a separate mount sheet for each group of specialist examinations. This would not constitute any difficulty if both the mount sheet and the report forms are standard. Much can be left to suit local needs. An example is shown at Figure 4. ECG and EEG tracings should be filed in the pocket at the back of the case folder.

STANDARDISATION LOCALLY

73. The documents referred to in the following paragraphs should be standardised as far as possible within hospital groups.

History and Continuation Sheet

74. The heading of these sheets could with advantage be standardised within Scotland. We have discussed elsewhere (paragraph 49) the minimum information required for patient identification. The detailed design of the rest of the sheet should be at the discretion of the individual specialties which will design this sheet specifically for the purposes for which they will be used. There may be multiple forms designed to meet individual clinical situations and also experimental forms for the extraction of information for data processing. It is recommended that those forms (except for experimental ones) should be standardised by specialty within the hospital group and should have the full approval of the hospital group records committee.

Investigation/Communication Sheet

75. An Investigation/Communication Sheet is not in our opinion absolutely necessary. Its use might be left therefore to the discretion of individual units. We consider that this is one of the documents which could be destroyed on completion of a patient's treatment.

Operation and Anaesthetic Documents

76. After taking legal opinion on the requirements for written consent to an operation, we decided not to go into detail on the wording of a Consent to Operation Form but to confine ourselves to stressing the importance of the act of obtaining permission to operate.

77. Operation and anaesthetic forms should be specially designed for the

particular purpose for which they are used. There may be several types of operation form for special operations and similarly for anaesthetics. We recommend that the size of the forms should be A4.

78. The name of the surgeon and anaesthetist should be recorded on operation notes.

Temperature, Pulse, Respiration and Blood Pressure Chart

79. In accordance with the terms of the Eighth Schedule prepared in terms of regulations dated 10th December, 1940 (S.I. 1940/2107) made under section 12 of the Public Records (Scotland) Act, 1937, four-hourly temperature charts, fluid intake or output charts or other ephemeral records may be destroyed upon the discharge of a patient provided that they reveal no abnormal conditions and that no notes are written on them.

80. All such records are transitory and should not be retained unless specifically marked for retention by a senior member of the medical staff of the unit concerned. We, therefore, recommend that any clinical information which is entered by custom on these charts should be recorded elsewhere, except in circumstances where the chart itself is to be retained.

Fluid Balance and Diabetic Charts

81. These documents are also of a transitory nature and similarly should not be retained unless specifically marked for retention by a senior member of the medical staff. Summaries could with advantage be prepared for retention.

Nursing Record

82. We approve of the practice of keeping an individual record for each patient and favour the visible edge card filing system which is the standard record at present in use in many hospitals. These records do not conform to international paper sizes. They should, however, be filed with the notes of current admission.

83. It is, however, strongly recommended that a nursing record using size A4 should be designed for Scottish hospitals.

Notification of Discharge and Discharge Letter

84. Many hospitals have already established systems of immediate notification of the discharge of a patient to a general practitioner. This notification can also include recommendations for future care. Accordingly we recommend that a simple form of notification of the patient's discharge should be sent to the general practitioner concerned in all cases. We are of the view that the design of this form should be kept as simple as possible to allow for flexibility in use. The design we recommend for the immediate notification is reproduced in Appendix E (Figure 5) and should be the special size 4½" x 7".

85. In many cases it will be necessary to follow the routine notification of discharge with a later more detailed discharge letter. The balance between these two must be a matter of policy for the hospital units concerned but we would urge that where discharge summaries are not routinely prepared adequate information should be available in the immediate notification of discharge if the latter is adopted as routine procedure.

86. It is often necessary for the hospital doctor to prescribe a drug or drugs to cover the period between the patient's discharge from hospital and the time he is seen by his general practitioner. It is therefore essential that a note of drugs supplied should be detailed in the notification of discharge.

87. General practitioners should be informed immediately of the death in hospital of any of their patients. By courtesy this is usually done by telephone but this should be followed where necessary by a detailed discharge letter.

Report Forms

ADVANTAGES OF STANDARDISATION

88. As reporting departments multiply, the need to be able to file their reports in the notes in some standard compact manner increases. As exchange of reports between hospitals increases the need to have a universally compatible system becomes pressing.

SYSTEM

89. The use of mount sheets and the gumming in of overlapping reports has been so widely approved by those who have adopted it recently that it would hardly be practicable, even if desirable, to attempt to introduce any other system.

GUMMING

90. The gummed edge should be along the top of the back of the report form, so that the forms are mounted overlapping from below upwards. The alternative of gumming along the left hand margin may be more convenient for reading the reports but it has been found to be unsatisfactory in practice. A thick narrow bar of overlapping gummed strips tends to develop along the margin of the mount sheet and in the course of time it frequently becomes detached.

STANDARD SIZE

91. Neither the size A5 (5⅞" x 8¼") nor that recommended by the Tunbridge Committee, namely size A6 (4⅛" x 5⅞") is suitable. A width of 7" is the maximum width of a sheet which can be mounted easily on a mount sheet of size A4 which is 8¼" wide leaving an adequate left hand margin. We therefore recommend the special size 4⅓" x 7" because it coincides with a size we have recommended earlier in the Report for letters to general practitioners (paragraph 59). Furthermore a depth of 4⅓" would allow duplication of three reports at a time on a foolscap size of machine. In addition long reports can be carried over to the back of the sheet, but written thereon in such a manner that it can be easily read when mounted.

VARIATION IN SIZE

92. Variations in size may be desirable as follows:

(a) *Large Sizes* — A few reports need larger sizes, e.g. post-mortem and neuropathology reports because of their exceptional length, and E.C.G. reports if they include tracings. These will have to be size A4 and treated as mount sheets with any special printing that may be necessary.

(b) *Smaller Sizes* — The paper strips which are likely to form the output of computerised biochemical laboratories of the future may introduce problems but for the present they can be pasted on standard report forms.

PRINTING

93. Wide variation is possible, but the following are some principles worth observing:

(a) The identification particulars of the patient, ward, etc., are important in ensuring that the report reaches the right patient, but not thereafter. They can therefore best occupy the top of the form.

(b) The narrow strip of the report along the bottom edge which is visible when mounted should be used for information that will enable the report to be identified with ease when mounted. It *must* therefore contain an indication of the nature of the specimen or examination, and the date, and should carry some indication of the department concerned, either by colour code or abbreviated name.

PHOTOCOPIED CUMULATIVE RECORD CARD

94. The maintenance in the laboratory of a record card for a series of related investigations on one patient is given as an example of another trend in reporting methods which can result in reports which are difficult to fit into the case folder. By this method each day's results on completion are entered as a new line on the card, and a photocopy of the whole card sent up to the ward as a report. Each photocopy includes all the previous results and therefore only the photocopy containing the last entry should be included on the mount sheet in the case folder as the permanent record. Most types of this record card currently in use are awkward in size for inclusion in the case folder and thought will require to be given to designing a card in accordance with the sizes recommended above for report forms. This is a matter which the reporting departments should keep in mind when re-designing new forms.

POST-MORTEM REPORTS

95. This report should be produced on a sheet size A4 and filed as the final document. The full post-mortem report is sometimes only available after considerable delay. The issue of provisional post-mortem summaries, giving only a list of macroscopic findings and a provisional opinion would then be appropriate on the special size.

MEDICAL SOCIAL WORKERS' REPORTS AND RECORDS

96. It has been represented to us that every time a patient is seen by a medical social worker a social report should be inserted in the case folder. This would be a brief report giving reasons for referral to the medical social worker, some indication of progress and a short summary. We recognise that the Social Services Department will require to keep a more detailed record in their own department. We are in agreement with the view of the Scottish Regional Committee of the Institute of Medical Social Workers that only the brief social report referred to above should be kept in the case folder and that the detailed social record should be kept by the Social Services Department to which reference could be made if considered necessary by the hospital doctor. We suggest

therefore that the social report should accord in size, etc. to the other report forms referred to above, i.e. special size 4½" x 7" or A4.

OTHER FORMS NOT IN THE CASE FOLDER

Request Forms

97. Request forms are usually filed by the department concerned and any change in them may need major changes in the department's filing system. On the wards the elimination of the variety of request forms of all sizes, shapes and colours would be a very substantial advantage, and a standard lay-out would make for quicker and more accurate completion. For a department which receives requests from a variety of sources outside its own hospital the standardisation of at least the size of such requests will reduce its filing problems. Several hospitals have successfully adopted a common request form for different departments (which need not necessarily be limited to laboratories) and we believe that such standardisation is possible and worthwhile. The sizes of request forms could be with advantage the special size 4½" x 7".

Notification to a General Practitioner of his Patient's Admission to Hospital

98. It is desirable that hospitals should inform general practitioners of the admission of their patients to hospital and that hospital authorities should consider what method of notification they should adopt when this admission has not been arranged directly by the general practitioner. In our view the size of this communication should be the special size 4½" x 7".

Post-Mortem Request and Authorisation Forms

99. These forms are used in connection with requests for and authorisation of post-mortem examinations, the performance of which is governed by the Human Tissue Act, 1961. These documents should be retained by the Pathology Department. They may also require to be specially designed for the differing clinical situations.

XIV. Mechanics of Management

Responsibility for Information Filed in the Record

100. We are of the view that the consultant in administrative charge of a unit should be clearly responsible for the quality of the medical records maintained in that unit and that responsibility for ensuring the accuracy and completeness of the Hospital In-Patient Records Summary Sheet and for the clinical summary attached lies with him and not with the medical records officer. In addition he should be responsible, in co-operation with the medical records officer, for the efficient handling of the records in his unit and for their expeditious return, suitably completed, to the Medical Records Office. In making this recommendation we recognise that it will be essential to have appropriate staffing at the unit level to undertake these duties.

Preparation of the Case Folder

101. It is fairly common practice for the folder to be initiated by medical and

nursing staff when patients are admitted as in-patients and in many instances this is due to the lack of suitable accommodation for centralised reception and registration of patients. Not only is this a waste of valuable time on the part of medical and nursing staff but it can result in a failure to obtain the accurate and essential information required to complete the Hospital In-Patient Records Summary Sheets.

102. It is essential therefore that every encouragement should be given to the provision of suitable facilities to enable the folder to be completed properly. Patients admitted from a waiting list will already have a folder but this is not always the case with emergencies. In larger hospitals consideration should be given to having reception staff on duty 24 hours a day when the combined duties of receiving "casualties" and documenting admissions would justify the cost. By this arrangement mechanical documentation equipment could then be sited in or adjacent to reception areas and clerical staff could perform a two-fold purpose.

103. The need for 24 hour cover would not arise in the smaller hospital but the hours of a member of the records staff could perhaps be extended up to 10 p.m. Thereafter a limited form of documentation could be carried out at ward level for the identification of the patient and recording of treatment. Full documentation would then be carried out the following morning.

104. Similarly there is a need to provide after office hours previous records for clinical purposes. In the larger hospitals this need would be met by a 24 hour service. In the smaller hospitals arrangements should be made to ensure that senior members of the hospital staff are fully conversant with the records system so that essential records can be made available to the clinician during the night.

Completion of the Record

105. During the active period of treatment of the patient either as an out or in patient, the record is constantly being created and added to, and even after discharge reports of various kinds relevant to the recent admission keep coming in. Frequently the case sheet cannot be completed or summarised for many days (and months for post-mortem reports). It has always been assumed in the past that the junior medical staff was responsible for the completion, editing and sorting of the case record. In view of the increasing complexity of the work of the junior medical staff and of the responsibility allocated to the consultant in administrative charge (see paragraph 100), we recommend that adequate secretarial assistance should be provided at ward level. This secretarial staff should be responsible, with the junior medical staff, for the completion, editing, sorting and summarising of all case records. A member of the clinical staff should examine and initial all laboratory and pathology reports etc. before they are filed by the secretarial staff.

Preparation of Hospital In-Patient Records Summary Sheet: Discharge Letters

106. These documents should be completed by the above-mentioned secretarial staff in co-operation with the junior medical staff. When the record has been compiled, edited and with the Hospital In-Patient Records Summary Sheet and any other special clinical summaries completed, it should be returned

expeditiously to the Medical Records Office. In general it is expected that this should be achieved within a few days of the discharge of the patient. The Medical Records Office should be responsible in general, for the final check of the Hospital In-Patient Records Summary Sheet before dispatch to the Scottish Home and Health Department.

Coding and Processing

107. As previously stated (paragraph 23) specialties within the group should be encouraged to develop summary and coded sheets for special purposes and also to develop supplementary coding and data processing systems within the group/regional data processing and computer systems.

XV. Departmental Registers

108. It is desirable that the medical records of each patient should be kept as a unit and the practice of keeping special departmental records should be discouraged where practicable. Many of these records have been found necessary in the ward to provide a summary of information which cannot at present be obtained so conveniently from the case notes. We would refer in particular to the following records:

DEPARTMENTAL REGISTERS AND OTHER RECORD BOOKS

(a) *Hospital Admission/Discharge Register.* This is essential only if details of admission and discharge dates and out-patient attendances are not included in the master index.

(b) *Post-Mortem Book.* This is an essential hospital medical register required in the administration of the Pathology Department.

(c) *Operation Book.* This must continue as an essential record. It is required for a number of administrative reasons, e.g. statistical, assessment of work load, records of the types of anaesthetic used, types of operation, etc., and has advantages for medico-legal purposes of keeping a record of the name of the surgeon, name of the anaesthetist, his nursing assistant and the person responsible for checking swabs.

(d) *Accident and Emergency Register.* This is an essential record in the primary treatment department of the accident and emergency unit. Particulars required are:— date and time; how brought in, i.e. whether police, ambulance, referred case or other means; name of patient, age, date of birth, address and disposal.

NURSING RECORDS

(a) *Nursing Report Books.* The nursing record for each patient, if the visible edge card system is adopted, can be conveniently included in the case folder and therefore it is unnecessary to keep a nursing report book.

(b) *Ward Register of Patients.* This is normally kept in the form of an 'Address Book'. It is not an essential ward record, but proves useful to a ward administrator in dealing with matters too trivial to be referred to the Records Department.

(c) *Record Books relating to Dangerous Drugs.* It is advisable that certain records should be kept in respect of the supply and use of dangerous drugs.

XVI. Records in Accident and Emergency Units

109. Many patients who attend an Accident and Emergency Unit may have no contact with other departments of the hospital. The casualty patient should be given a "casualty number", even when he is known to have a unit number already for that hospital. A case folder should not be opened, however, unless the patient subsequently returns to any other department of the hospital for treatment. If a case folder were subsequently raised for such a patient, the casualty record should, of course, be incorporated in it. These recommendations are made on the assumption that a master index would be kept at all hospitals and that it would be feasible to have a system whereby records or at least information from the master index would be available 24 hours a day (paragraph 104 refers).

110. It is necessary to keep the casualty patient's primary record in a separate register in the Accident and Emergency Unit.

111. Each hospital group should design the casualty record system best suited to itself. An example of a system in use in a Scottish hospital is shown in Appendix D.

XVII. Records in Maternity, Mental and Mental Deficiency Hospitals

112. We are of the view that the medical records for such hospitals should be kept broadly on the lines recommended by us for other hospitals and that they should form part of the unit system for a hospital group or region although such records, while within a unit system, might for convenience be stored separately in the individual hospital concerned.

XVIII. Summary of Main Recommendations

1. Every effort should be made to preserve the confidential nature of medical records. (paragraph 29)

2. Medical records should be retained for a minimum period of 25 years following the last visit of a patient. The records should be stored at hospital level for the first six years to enable instant recall and thereafter maintained in less effective storage which should allow recall within 24/48 hours. For the latter category, storage on a regional basis is contemplated. (paragraphs 32, 34)

3. Each Regional Hospital Board should set up a Medical Record and Data Processing Section to develop medical record systems and encourage research within their own region. (paragraph 26)

4. Hospital Medical Records Committees should be established in hospital groups to consider and decide the form and contents of records to be used in the hospital or group where this has been left to the discretion of hospitals. (paragraph 27)

5. The continued introduction of unit systems in hospitals and groups of hospitals must be organised within a regional plan. (paragraph 40)

6. We recommend that the Health Services Research and Intelligence Unit of the Scottish Home and Health Department should promote studies and

research into data processing and methods of record keeping etc. (paragraph 53)

7. We recommend that the case folder and paper sizes should be standardised and also the general heading of case notes and certain documents, such as the Hospital In-Patient Records Summary Sheet, the general practitioner's letter of referral, the prescription sheet, the mount sheet and reports for inclusion in the case folder. (paragraph 41)

8. International paper sizes A4 and A5 should be mainly used, but for reports and letters to general practitioners and certain other reports, a special size is recommended. (paragraph 59)

9. All records should be retained in the case folder except those of a transitory nature such as intake and output charts and other aides-memoires which may be destroyed on a patient's discharge at the discretion of the consultant in charge of the patient. (paragraph 42)

10. We recommend that the Hospital In-Patient Records Summary Sheet should be printed on yellow paper and all other documents for inclusion in the case folder should be of white paper. (paragraph 60)

11. Colour flashes or a colour print system on a white background should be used to distinguish laboratory reports and specific colours are recommended. Reports from other departments such as E.C.G. and X-ray etc. should be on white paper, with the name of the issuing department printed on the bottom left-hand corner of all reports. (paragraphs 61, 62)

12. Guidance is given on paper qualities. (paragraph 64)

13. On the outside of the case folder there should be printed only the name of the hospital, the patient's name and the identification number. In bold letters there should be printed the phrase "The information enclosed in this record is highly confidential" (or some phrase to that effect). The words "Not to be handled by the patient" could be added where considered advisable by the Group Medical Records Committee. Information required on the inside of the folder is outlined. (paragraph 66)

14. A standard form of letter for referral by a general practitioner of his patient to hospital should be introduced. (paragraph 68-70)

15. A visible edge card system should be used for ordering drugs by medical staff. It should be a composite card used to record both drug prescription and administration. (paragraph 71)

16. Mount sheets should be a standard size with sufficient space at the top of the form for a stick-on mechanically printed label and reports etc. should be mounted overlapping from the bottom of the sheet upwards. (paragraph 72)

17. The practice of keeping a nursing record for each patient is approved and the visible edge card filing system is recommended. (paragraph 82)

18. Report forms should normally be the special size. It is important that the narrow strip of the report should contain an indication of the nature of the specimen or examination, the date and some form of identification of the department concerned since this strip is visible when the report is mounted. (paragraphs 91, 93)

19. The consultant in administrative charge of a unit should be responsible for the quality of medical records maintained there and also for ensuring the accuracy of completeness of the Hospital In-Patient Records Summary Sheet. In addition, he should be responsible in co-operation with the medical records officer, for the efficient handling of the records in his unit and their expeditious

return on completion to the Medical Records Office. (paragraph 100)

20. In the larger hospitals consideration should be given to providing a 24 hours service for documentation of patients' records and availability of records for clinical purposes. Less elaborate arrangements could be made for the smaller hospitals. (paragraphs 102-104)

21. We recommend that adequate secretarial assistance should be provided at ward level and that this staff should be responsible, with the junior medical staff, for the completion, editing, sorting and summarising of all case records. (paragraph 105)

22. Comments are made on the keeping of Departmental Registers. (paragraph 108)

23. Advice is given on the form of records in Accident and Emergency Units. (paragraphs 109-111)

24. The medical records for maternity, mental and mental deficiency hospitals should be kept broadly on the lines recommended for other hospitals and should form part of the unit system for a hospital group or region. (paragraph 112)

Finally we wish to record our appreciation of the assistance given to us by all the officials in the Scottish Home and Health Department and individuals in the National Health Service and associated organisations whom we consulted both formally and informally, and also of the invaluable contribution by our joint secretaries Dr J. F. Kirk and Miss M. B. M. Talbot.

(*Signed*) JAMES WALKER,
CHAIRMAN
on behalf of the Sub-Committee

October, 1966

APPENDIX A

Glossary of Medical Terms Commonly Used

I. General

(i)	A Medical Record	Any document on which information about a person in a professional relationship with a doctor is recorded.
(ii)	Case Papers (Sometimes given as The Medical Record)	A dossier comprising medical record documents of an individual patient.
(iii)	Case Folder	A folder enclosing the patient's case papers.

II. Documents in Case Folder

(i)	Hospital In-Patient Records Summary Sheet	A form containing the personal and administrative details relating to an individual patient, a summary of the admission and the discharge diagnosis.
(ii)	General Practitioner's Letter of Referral	A letter from a general practitioner to a hospital requesting a consultation appointment for his patient. It may contain the general practitioner's clinical note for the consultant.
(iii)	History and Continuation Sheet	The part of the patient's case papers containing the doctor's clinical notes and details recorded by the doctor of the patient's treatment and progress.
(iv)	Investigation and Communication Sheet	A form or card on which the doctor records all instructions for the management of the patient including investigations and treatment other than prescriptions for drugs.
(v)	Drug or Prescription Sheet	A form for recording by the doctor of all prescriptions for drugs and drugs administered.
(vi)	Consent Form	A form signed by the patient (and/or the patient's representative) consenting to the performance of an operation and the administration of an anaesthetic.
(vii)	Operation and/or Anaesthetic Sheet	A record of a surgical operation and of the associated anaesthetic procedure.
(viii)	Temperature, Pulse, Respiration and Blood Pressure Chart (Commonly known as the TPR Chart)	A chart showing graphically recordings of patient's temperature, pulse, respiration and blood pressure.
(ix)	Fluid Balance Chart	A chart for recording details of a patient's intake and excretion of fluids.
(x)	Diabetic Chart	A chart for recording data concerning the control of diabetes.

(xi)	Nursing Record	A report sheet for each patient on which the nurses responsible for his care record notes on nursing treatment and significant events during the patient's stay in hospital.
(xii)	Post Mortem Report	The Pathologist's Report of the post-mortem examination including, where appropriate, a record of the histological or other laboratory examination of post-mortem material.
(xiii)	Discharge Notification and Letter	A letter sent by a hospital doctor informing a patient's general practitioner of the patient's discharge from hospital. It also contains details of diagnosis, treatment and drugs recommended, and information given to the patient and/or relative.
(xiv)	Standard Mount Sheet	A sheet included in the case papers for the purpose of affixing reports returned from special Departments.
(xv)	Report Forms	Forms completed by the Department concerned recording the results of an investigation requested by the doctor in charge of the patient.
(xvi)	Request Forms	A form completed by the doctor requesting investigation of the patient, or of specimens collected from the patient in special hospital Departments, e.g. Departments of Radiology, Pathology, Electro-cardiography, Electro-encephelography, Medical Photography.
(xvii)	Social Report	A brief summary by the medical social worker giving reasons for referral of the patient and indication of the patient's progress.
(xviii)	Accident/Emergency Sheet	The clinical record used in the part of the Accident and Emergency Unit where patients are sent initially and are given primary treatment or investigation.

III. Documents not Contained in the Case Folder

(i)	Social Record	Detailed record of the medical social worker's investigation and treatment of a patient which is kept by the Social Services Department and may be sent to the hospital doctor on request.
(ii)	Notification to General Practitioner of a Patient's Admission to Hospital	A letter sent by the hospital to the patient's general practitioner informing him of the patient's admission to hospital.
(iii)	Post-Mortem Request and Authorisation Forms	Forms addressed to the hospital pathologist containing (a) a request from a doctor for the performance of a post-mortem examination, and (b) an authorisation by the person lawfully in possession of the body for the conduct of the post-mortem examination expressed in terms which fulfil the requirements of Sections 2(2) and 1(2) of the Human Tissue Act, 1961. The forms are often conveniently combined on a

single piece of paper which may also provide for a signed statement authorising the removal of the eyes for therapeutic purposes. These forms are necessary for all post-mortem examinations except those authorised by the Procurator Fiscal; they are usually retained and filed in the Pathology Department and are not included in the case folder.

IV. Other Terms

(i)	Medical Record Card (G.P.) (Form E.C.7 (Scotland) (Male) E.C.8 (Scotland) (Female)).	A card used by general practitioners for recording the clinical and progress notes of a patient.
(ii)	Medical Record Envelope (Form E.C.5 (Scotland) (Male) E.C.6 (Scotland) (Female)).	An envelope used by general practitioners for filing the medical record card and also letters and reports from hospitals and other medical practitioners about the patient.
(iii)	Provisional Diagnosis	Diagnosis or listing of the illness bringing the patient to hospital.
(iv)	Discharge Diagnosis	The diagnosis which reflects the latest information available recorded at the time of the patient's discharge.
(v)	Diagnostic Index	A record consisting of pages or cards, each with a specific diagnostic title listing patients treated for that condition.
(vi)	Filing by Terminal Digit System	The system of filing medical records according to the last two digits of the unit number.
(vii)	Micro-filming	The reduction and reproduction of documents by means of film.
(viii)	Mechanical Registration	Equipment used for printing a patient's identification details and other administrative information on medical record documents.

Methods of Filing

I. Filing Order within the Case Folder

1. Because the various documents relating to a patient's admission to hospital (and to a less extent out-patient attendance) are not all completed at the same time, or even held in one place, it appears preferable to accumulate the completed case-papers relating to an individual patient either in a ring file or pocket of the folder and then to incorporate them in the body of the record in an agreed sequence following the patient's discharge.

2. It is suggested that all case-papers should be filed at the bottom of the fastening, each new sheet being attached *BELOW* the preceding one, thereby ensuring that when two sides of a sheet are written upon, both the time sequence and customary position of the next entry will follow automatically. Although this is a departure from current practice it is simply achieved by reversing the mounting clips and allows the growth of the record to assume the usual form of a book.

3. As mentioned in the body of the report there are essentially two conflicting filing systems favoured by clinicians. In one, the personal notes of each specialist or department are filed together (hereafter referred to as "specialty order") and in the other, notes are filed as a chronological sequence of episodes irrespective of specialty (hereafter referred to as "episode order"). With "specialty order" it is more convenient to hold the papers of each department separately within a large pocket in the folder and not fastened to one another. The case-papers of each individual department may be held together by means of "Treasury" ("India") tags. With "episode order" it is more convenient to fasten all the case-papers together by means of an annealed brass or nylon flexible strip. Only a small pocket in the folder is then required to hold current case-papers until the patient has been discharged. This does not mean that one method of filing excludes an alternative method of fastening. It is possible with "specialty order" to fasten all case-papers on one flexible strip but this involves removing the whole of the accumulated clinical notes to add new departmental case-papers in their correct position; it is also possible to fasten the case-papers of each individual department by means of a flexible strip but this is likely to add considerably to the bulk of the record.

4. There are, however, a number of advantages to be gained by using "specialty order". By this method it is possible to file within the records folder, but separate from the clinical notes, all correspondence and investigation report forms. This is an important suggestion because the grouping together of letters will allow clinicians to review quickly, with no searching, the chronological sequence of events affecting their patients. The proximity of investigation reports, also chronologically arranged would show not only all the investigations carried out, but the results. Such an arrangement would cause the least inconvenience, would provide the maximum of information to the general user and would afford the specialist the advantage of having all his personal notes together. Filing reports separately in this way is of particular advantage with the increasing introduction of photocopying techniques of laboratory record cards. This method involves, on each occasion, the removal of the old report and the insertion of a new one carrying, of course, all previous results. With a separate section for investigation reports, filing would be easier and the duplication of results in each specialty or within each episode of illness would be avoided.

5. The major disadvantage of a separate report section is the fact that if notes are kept in a file employing any kind of clip, the only satisfactory place for the collection of mount sheets is at the bottom of the clip. In this case, if new mount sheets are to be added, the clinical notes have to be removed from the clip, although more complex folders may obviate this difficulty. With "specialty order", filing case notes in a pocket of the folder, laboratory reports and correspondence can be then clipped to the record spine: in this way reports would be quickly found within the folder and new mount sheets easily added.

6. Furthermore the "specialty order" method of filing will allow some departments and specialties to adopt appropriate data processing and computer facilities without disrupting or changing the rest of the record. This would not be possible with "episode order" of filing and some such flexible approach will be required to allow the gradual and phased introduction of these newer techniques.

7. Both main alternatives carry advantages: the "episode order" is at present common

practice but the "specialty order" is perhaps more flexible and so able to accommodate the inevitable changes of the next few years. Compromise between the two systems is possible but one or other must be maintained consistently by each hospital or group.

8. The final choice will depend upon a number of factors but whichever system is adopted it is hoped that careful consideration will be given to the advantages of filing laboratory and investigation reports in a separate section. The chief advantage lies in the ease of finding particular reports in spite of multiple admissions to different departments. It also makes easier the accommodation of non-standard reports which need special mount sheets and in addition saves paper, since the number of mount sheets bearing only one or two reports is reduced. This is particularly true when separate mount sheets for reports from different departments or groups of departments are used because this practice may easily lead to five mount sheets with only one report on each. (See paragraph 72).

9. Once the major filing system has been decided then, to a large extent, the method of fastening papers within the folder follows automatically. The actual sequence of case-papers will inevitably depend upon the order of out-patient attendances and admissions but, accepting this variable, the final order should be:

(a) "SPECIALTY ORDER"

Within the folder, departmental records should be arranged alphabetically and within the departmental sections of the folder, clinical notes relating to different admissions or attendances should be entered in chronological order.

Within each admission the sequence of papers should be:

(i) out-patient sheet or sheets (where appropriate)
(ii) Hospital In-Patient Records Summary Sheet
(iii) clinical sheets (appropriate to the particular admission)
(iv) prescription sheets
(v) consent form for operation (where appropriate)
anaesthetic sheet
operation sheet
(vi) nursing notes
(vii) temperature charts (when retained)
(viii) other forms (depending on agreement with a group regarding documents to be retained)
(ix) post-mortem report (where appropriate)
(x) hospital in-patient records summary sheet of the next admission — or out-patient sheet (whichever is appropriate to the next chronological event)
(xi) and so on.

Correspondence and reports would be filed separately on the same fastening (or with double spine folders on adjacent fastenings) subsequent letters being added to the top and additional laboratory mount sheets to the bottom.

(b) "EPISODE ORDER"

This is the common practice, all notes being held on the same fastening in chronological order of admission or attendance irrespective of department or specialty.

Within each admission the sequence of papers should be:

(i) out-patient sheet or sheets (where appropriate)
(ii) out-patient letters (where appropriate)
(iii) out-patient mount sheets (where appropriate)
(iv) Hospital In-Patient Records Summary Sheet
(v) clinical sheets (appropriate to the particular admission)
(vi) prescription sheets
(vii) consent form for operation (where appropriate)
anaesthetic sheet
operation sheet
(viii) nursing notes
(ix) temperature charts
(x) in-patient correspondence
(xi) in-patient mount sheets
(xii) other forms (depending on agreement within a group regarding documents to be retained)

(xiii) post-mortem report (where appropriate)
(xiv) Hospital In-Patient Records Summary Sheet of the next admission — or out-patient sheet (whichever is appropriate to the next chronological event)
(xv) and so on.

Laboratory and other reports may be filed separately and, as already stated, it is hoped that this point will be given careful consideration.

10. It would be essential within either "specialty order" or "episode order" that chronological sequence be followed, even if the use of the appropriate sheet meant discontinuing one that was only partially completed. For example, an out-patient attendance after hospital admission would require a new out-patient sheet even if a partially completed one relating to an earlier attendance at the specialty was available in the notes. Examination of existing case-papers shows that the adoption of this procedure would not be unduly wasteful compared with the advantage of knowing where the next chronological entry would be found.

11. If "specialty order" were adopted by a hospital or group it would be essential that everyone using the case record understood that no part of the contents of the case folder could be removed and carried elsewhere, independently of the case folder.

12. Quite obviously some measure of compromise is possible between the two systems but, if care is not exercised in making the choice, the ultimate amount of handling by the records staff may prove considerable. Many hospitals already use a variety of different folders and any move towards standardisation would require a considerable measure of change. For this reason it was felt that the fastening and folder best suited to the work-load and organisation of any particular hospital is a matter for the individual medical records officer.

13. Although we felt that it would be wrong to dictate to hospitals which system should be adopted, we hope that in view of the inevitable changes that must be introduced, sooner or later, in the handling of medical information, plans will be prepared now for the adoption of methods by which such changes can be achieved.

II. Filing of the Record

14. It is felt that shelving should be the recommended filing medium, but while we accept static shelving for current filing, we recommend that mobile shelving can be used for non-current filing where space is limited. This however is inevitably related to the individual Medical Records Officer's views on how many records should be currently kept. We understand that suitable shelving is available which could accommodate hospital medical records of the international paper sizes recommended.

15. The terminal digit filing system envisages using a six digit unit number to identify the patient's record. The system requires the creation of one hundred sections into which the records are primarily filed by the last two digits of the unit number i.e. 00 to 99. Within each section the records are then filed in sub-sections numerically by the next digit or digits, depending on the size of the filing installation, e.g. if the record number is 123456 then this record will be primarily filed in the 56 section, subsequently in subsection 4, and thereafter numerically, — 123. The record preceding this example would be 122456 and the one following would be 124456. This means that records are evenly distributed throughout the filing area by the last two digits of the record so that more staff can withdraw and file records simultaneously as opposed to a straight numerical system. The terminal digit filing system has a definite advantage over straight numerical filing in which activity tends mainly to be concentrated at the end of the numerical sequence to which the newly created records are being added. In addition, since the terminal digit system has a present number of sections which accommodate a predetermined number of records, the Medical Records Officer can more effectively plan the layout and the exact amount of equipment required for current filing.

APPENDIX C

Paper Quality

1. The following specifications, in general terms, are intended to serve as a guide and are reproduced with the approval of the Tunbridge Committee from their Report on Standardisation of Hospital Medical Records:—

Writing Surface

2. Suitable for ink, ballpoint pen, pencil and typewriter. Suitable also for printing with metal, plastic or paper plates.

Erasing Quality

3. Not important, but it is convenient if typewriting can be erased.

Opacity

4. In some instances it will be necessary to write on both sides of a form and in these cases the opacity must be such that there is a minimum of "show-through".

Thickness, Bulk, Weight and Toughness

5. Capable of frequent handling without becoming "dog-eared". Should withstand wear at punch holes. Not too bulky. Varying thickness will be required for different forms, e.g. X-ray and pathology reports need not be quite so heavy.

Translucency to Ultra-Violet Light

6. Should be suitable if required for this method of photocopying.

Printing

7. Should be suitable both for typeset and offset, and will be required with the "grain" the correct way for offset. Thus the following forms should be of a strong bond or cartridge of good white shade preferably of an all-chemical wood finish, gelatine, or starch-surfaced-sized high finish, substance approximately 72 g.s.m.: History Sheets, Investigation/Communication Sheets, Nursing Records (all on A4) (but not including the Standard Mount Sheet — see below).

Carbonised Forms

8. "No Carbon Required" paper may be required and carbon backed paper may also be used. Papers should be suitable for whichever process of carbonising or spotting is selected. They should be of good white shade, substance 47 g.s.m.

Standard Mount Sheet

9. To withstand wear at punch holes, this will have either to be of heavier and stronger paper, or to be reinforced at the punch holes.

Casualty Record System in use in a Scottish Hospital

The following system has much to commend it. The patient's name, address, age, occupation, etc., together with the general practitioner's name and address, is written on a sheet at entry (sample given overleaf). These details copy on to a second coloured sheet, the name and address again copying on to a card which constitutes the X-ray request form. These sheets and card, when completed, are clipped to a suitable board to be sent with the patient to the Medical Officer on duty. When the condition is regarded as of minor importance, the completed front sheet is filed in the Accident and Emergency Department, the copy (coloured yellow) is placed in an envelope with a transparent panel, and forms the doctor's letter. If the patient is admitted the front sheet accompanies him to the ward and the second sheet forwarded to the general practitioner informing him of the "disposal" of his patient. A large proportion of cases attending Accident and Emergency Departments are X-rayed. If no X-ray is necessary, the card is destroyed. This system of documentation is not only labour-saving in terms of form-filling but ensures that the general practitioner is always kept informed without the necessity of letter-writing.

SAMPLE OF RECORD SHEET

Surname	Maiden Name	Christian Name	Number	(Name of Hospital) CASUALTY DEPARTMENT
Address			PLEASE LEAVE BLANK	
Date	Age DoB	Occupation		
History				

Examination

Sites X-Rayed and Findings

Treatment Recommendations etc.

Tetanus Toxoid Record

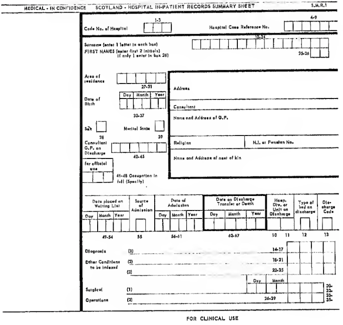
Dr.

DISPOSAL
Discharged
Referred to G.P.
Clinic
Referred to Ward No.....
Admitted to Ward No.....
....
....
....
....

....
Signed

APPENDIX E

Documents referred to in the Report



MEDICAL - IN CONFIDENCE SCOTLAND - HOSPITAL IN-PATIENT RECORDS SUMMARY SHEET S.M.R.1

Code No. of Hospital 1-3

Hospital Case Reference No. 4-9

Surname (enter 1 letter in each box) 10-24

FIRST NAMES (enter first 2 initials)
(If only 1 enter in box 26) 25-26

Area of residence 27-31

Date of Birth Day Month Year 32-37

Sex 38

Marital State 39

Consultant G.P. on Discharge 40-45

for official use

46-48 Occupation in full (Specify)

Address

Consultant

Name and Address of G.P.

Religion

N.I. or Pension No.

Name and Address of next of kin

Date placed on Waiting List			Source of Admission	Date of Admission			Date on Discharge Transfer or Death			Hosp. Div. or Unit on Discharge		Type of bed on discharge	Discharge Code
Day	Month	Year		Day	Month	Year	Day	Month	Year				
49-54			55	56-61			62-67			10	11	12	13

Diagnosis (1) 14-17

Other Conditions to be indexed (2) 18-21

(3) 22-25

Day Month

Surgical (1)

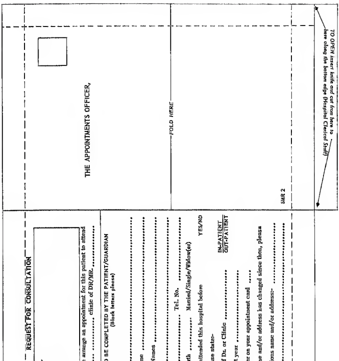
Operations (2) 26-29

30-32-33-35-

FOR CLINICAL USE

(Size A.4)
Fig. 1

General Practitioner's Letter of Referral (SMR2)



REQUEST FOR CONSULTATION

From:-

Please arrange an appointment for this patient to attend the .... clinic of DR/MR. ....

TO BE COMPLETED BY THE PATIENT/GUARDIAN
(Block letters please)

Surname ....

Maiden Name ....

Christian Names ....

Address ....

.... Tel. No. ....

Date of Birth .... Married/Single/Widow(er)

Have you attended this hospital before YES/NO

If YES please state:-

(i) Name of Dr. or Clinic .... IN-PATIENT / OUT-PATIENT

(ii) In what year ....

(iii) Number on your appointment card .....

If your name and/or address has changed since then, please state previous name and/or address:- ....

....

THE APPOINTMENTS OFFICER,

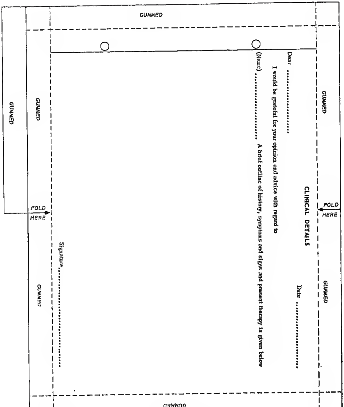
FOLD HERE

SMR 2

TO OPEN insert knife and cut from here to here along the bottom edge (Hospital Clerical Staff)

(A5 less gummed edges)

Fig. 2


GUMMED
GUMMED
GUMMED
GUMMED
GUMMED
GUMMED
GUMMED
FOLD HERE
FOLD HERE

CLINICAL DETAILS

Date ....

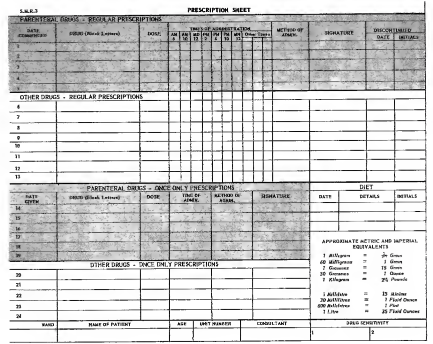
Dear ....

I would be grateful for your opinion and advice with regard to

(Name) .... A brief outline of history, symptoms and signs and present therapy is given below

Signature.............................

Reverse side of Fig. 2



S.M.R.3

PRESCRIPTION SHEET

PARENTERAL DRUGS - REGULAR PRESCRIPTIONS

DATE COMMENCED	DRUG (Block Letters)	DOSE	TIMES OF ADMINISTRATION AM 6	AM 10	MD 12	PM 2	PM 6	PM 10	MN 12	Other Times			METHOD OF ADMIN.	SIGNATURE	DISCONTINUED DATE	INITIALS
1																
2																
3																
4																
5																
OTHER DRUGS - REGULAR PRESCRIPTIONS																
6																
7																
8																
9																
10																
11																
12																
13																

PARENTERAL DRUGS - ONCE ONLY PRESCRIPTIONS

DATE GIVEN	DRUG (Block Letters)	DOSE	TIME OF ADMIN.	METHOD OF ADMIN.	SIGNATURE
14					
15					
16					
17					
18					
19					
OTHER DRUGS - ONCE ONLY PRESCRIPTIONS					
20					
21					
22					
23					
24					

DIET

DATE	DETAILS	INITIALS

APPROXIMATE METRIC AND IMPERIAL EQUIVALENTS

1 Milligram	=	*$\frac{1}{60}$ Grain*
60 Milligrams	=	*1 Grain*
1 Grammes	=	*15 Grain*
30 Grammes	=	*1 Ounce*
1 Kilogram	=	*2¼ Pounds*
1 Millilitre	=	*15 Minims*
30 Millilitres	=	*1 Fluid Ounce*
600 Millilitres	=	*1 Pint*
1 Litre	=	*35 Fluid Ounces*

WARD	NAME OF PATIENT	AGE	UNIT NUMBER	CONSULTANT	DRUG SENSITIVITY	
					1	2

(Size A4)
Fig. 3

SMR 4

(Identification particulars will be the same as in SMR 1 — Fig. 1. This box should be not less than 4″ × 1″ for mechanically printed label).

..............................HOSPITAL

STANDARD MOUNT SHEET

....

....

....

....

....

....

....

....

....

....

....

....

(Size A.4)
Fig. 4

SMR S

NOTIFICATION OF DISCHARGE

Name and Address
of Hospital

Dear Dr............................

Your patient...

(address)...

....

under the care of...

will be discharged on
....
is being transferred to

Diagnosis:—...

....

Treatment and/or Recommendations:—......................................

....

....

....

The patient has been given a limited supply of...........................

....

....

....

An appointment has/has not been made for further attendance as an out-patient.

Yours sincerely,

....

Date ....

(Special Size 4⅓″×7″)

Fig. S

Printed in Scotland for Her Majesty's Stationery Office
by Highland Printers Ltd., Inverness Wt. 72661 K16